



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ENGS PHARMACY LLC
PO BOX 2686
STAFFORD TX 77497

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

FEDERAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number

M4-12-2943-01

MFDR Date Received

May 22, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "no payment after 1st & 2nd attempt"

Amount in Dispute: \$3,558.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent, or its agent, did not respond to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 20, 2012	MELOXICAM 15 MG TABLET – 90 Units Generic NDC: 68382005101	\$549.10	\$549.05
January 20, 2012	TIZANIDINE HCL 4 MG TABLET – 150 Units Generic NDC 00185440051	\$278.80	\$278.73
January 20, 2012	ZOLPIDEM TARTRATE 10 MG TAB – 60 Units Generic NDC: 13668000801	\$350.90	\$350.90
January 20, 2012	TRAMADOL HCL 50 MG TABLET – 240 Units Generic NDC: 65162062710	\$254.20	\$254.20
February 17, 2012	HYDROCODON-APAP 10-325 – 200 Units Generic NDC: 00603388721	\$178.80	\$178.75
February 17, 2012	TRAMADOL HCL 50 MG TABLET – 240 Units Generic NDC: 65162062710	\$254.20	\$254.20
February 17, 2012	TIZANIDINE HCL 4 MG TABLET – 150 Units Generic NDC 00185440051	\$278.80	\$278.73
February 17, 2012	ZOLPIDEM TARTRATE 10 MG TAB – 60 Units Generic NDC: 13668000801	\$350.90	350.90
March 16, 2012	TIZANIDINE HCL 4 MG TABLET – 150 Units Generic NDC 00185440051	\$278.80	278.73

March 16, 2012	HYDROCODON-APAP 10-325 – 200 Units Generic NDC: 00603388721	\$178.80	178.75
March 16, 2012	TRAMADOL HCL 50 MG TABLET – 240 Units Generic NDC: 65162062710	\$254.20	254.20
March 16, 2012	ZOLPIDEM TARTRATE 10 MG TAB – 60 Units Generic NDC: 13668000701	\$350.90	\$350.90

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Texas Labor Code §401.011(22) defines "health care provider" as a "health care facility" or "health care practitioner."
3. Texas Labor Code §401.011(19)(E) defines "health care" to include a prescription drug, medicine, or other remedy.
4. Texas Labor Code §401.011(20) defines "health care facility" as a hospital, emergency clinic, outpatient clinic, or other facility providing health care.
5. 28 Texas Administrative Code §134.503, adopted to be effective January 3, 2002; amended to be effective October 23, 2011, set out the reimbursement guidelines for pharmaceutical services applicable to this dispute and is the version used throughout this decision.
6. 28 Texas Administrative Code §133.20, titled *Medical Bill Submission by Health Care Provider*, sets out the billing requirements.
7. The services in dispute were reduced/denied by the respondent with the following reason codes: for dates of service:

Explanation of benefits were not submitted by either party.

Issues

1. Were all the services in dispute filed in the form and manner prescribed by the division?
2. Is Eng's Pharmacy a health care provider?
3. Did the requestor bill in accordance with 28 Texas Administrative Code §134.503?
4. Is the requestor entitled to additional reimbursement?

Findings

1. This medical fee dispute was filed on May 22, 2012. The dates of service in dispute are January 20, 2012, February 17, 2012 and March 16, 2012; therefore, the requestor has met the requirements of 28 Texas Administrative Code §133.307(c) and the dates of service are eligible for review
2. Review of the documentation submitted finds that Eng's Pharmacy, the requestor in this medical fee dispute, is the health care provider because it is a health care facility as defined by the Texas Labor Code.
3. 28 Texas Administrative Code §134.503(b) states that "For coding, billing, reporting, and reimbursement of prescription and nonprescription drugs or over-the-counter medications, Texas workers' compensation system participants shall apply the provisions of Chapters 133 and 134 of this title (relating to General Medical Provisions and Benefits—Guidelines for Medical Services, Charges, and Payments, respectively). In accordance with 28 Texas Administrative Code §134.503(c) the insurance carrier shall reimburse the health care provider or pharmacy processing agent for the prescription drugs the lesser of: (1) the fee established by the following formulas based on the average wholesale (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed: (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + \$4.00 dispensing fee = reimbursement amount; (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + \$4.00 dispensing fee = reimbursement amount; (C) When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either subparagraph (1)(A) or (B) of this subsection; or (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the: (A) health care provider; or (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The maximum allowable reimbursement (MAR) is therefore based on the average wholesale price (AWP) as follows:

Dates of Service	Prescription Drug	Billed Amount	\$134.503 (c) (3)(A)	Carrier Paid	Due
January 20, 2012	MELOXICAM 68382005101	\$549.10	$((4.84490 \times 90) \times 1.25) + \$4 = \$549.05$	\$0.00	\$549.05
January 20, 2012	TIZANIDINE HCL 00185440051	\$278.80	$((1.46520 \times 150) \times 1.25) + \$4 = \$278.73$	\$0.00	\$278.73
January 20, 2012	ZOLPIDEM TARTRATE 13668000801	\$350.90	$((4.62540 \times 60) \times 1.25) + \$4 = \$350.91$	\$0.00	\$350.90
January 20, 2012	TRAMADOL HCL 65162062710	\$254.20	$((0.83400 \times 240) \times 1.25) + \$4 = \$254.20$	\$0.00	\$254.20
February 17, 2012	HYDROCODON- APAP 00603388721	\$178.80	$((0.69900 \times 200) \times 1.25) + \$4 = \$178.75$	\$0.00	\$178.75
February 17, 2012	TRAMADOL HCL 65162062710	\$254.20	$0.83400 \times 240 \times 1.25) + \$4 = \$254.20$	\$0.00	\$254.20
February 17, 2012	TIZANIDINE HCL 00185440051	\$278.80	$((1.46520 \times 150) \times 1.25) + \$4 = \$278.73$	\$0.00	\$278.73
February 17, 2012	ZOLPIDEM TARTRATE 13668000801	\$350.90	$((4.62540 \times 60) \times 1.25) + \$4 = \$350.91$	\$0.00	\$350.90
March 16, 2012	TIZANIDINE HCL 00185440051	\$278.80	$((1.46520 \times 150) \times 1.25) + \$4 = \$278.73$	\$0.00	\$278.73
March 16, 2012	HYDROCODON- APAP 00603388721	\$178.80	$((0.69900 \times 200) \times 1.25) + \$4 = \$178.75$	\$0.00	\$178.75
March 16, 2012	TRAMADOL HCL 65162062710	\$254.20	$0.83400 \times 240 \times 1.25) + \$4 = \$254.20$	\$0.00	\$254.20
March 16, 2012	ZOLPIDEM TARTRATE 13668000701	\$350.90	$((4.62540 \times 60) \times 1.25) + \$4 = \$350.91$	\$0.00	\$350.90
TOTALS				\$0.00	\$3,558.04

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$3,558.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$3,558.04 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

June 28, 2012

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC

Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.